DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

INITIAL SERVICE PLAN

Form 1-15 I

SOURCE OF FUNDING: ❑ DD/MR WAIVER ❑ BRAIN INJURY WAIVER ❑ NON-WAIVER

Plan's Effective Date:___/___/___ MM DD YY	Plan's End Date:___/___/___ MM DD YY

Name	Address	Phone Number
Person:		( )-
Support Coordinator:		( )-

Support Coordination (formerly Case Management) serves the purpose of: (a) establishing and maintaining the individual in the support system and if applicable in the Home and Community-Based Waiver in accordance with program requirements and the individual's assessed support needs and (b) coordinating the delivery of quality waiver and non-waiver services.

Outcome: Please check all that apply:

❑ all outcomes listed below
❑ establish Medicaid financial and categorical eligibility,
❑ gain access to waiver supports, state plan services, medical, social, and educational assessments and services, and any other services, regardless of the funding source,
❑ develop a personal budget based on the individual support plan,
❑ identify the supports necessary to insure the individual's health and safety,
❑ write and update personal social history,
❑ write, coordinate, integrate, and assure the implementation of the individual's support plan, and
❑ ensure a person-centered plan is written and implemented.
❑ provide ongoing monitoring to assure the provision and quality of the supports identified in the individual's plan,
❑ provide an initial assessment and ongoing reassessment of the individual's level of care determination,
❑ review the individual's support plan as needed/at least annually
❑ instruct the individual/legal representative/family how to independently obtain access to services and supports, regardless of funding source, and
❑ provide discharge planning services up to 30 days immediately prior to the date an individual living in an ICF/MR is admitted to the waiver.
❑ other (please specify)_____

_____

_____

Expected Start Date: ___/___/___ MM DD YY	Intensity:	Name/Title of Provider:
Amount/Frequency:		
Duration:		

My support coordinator has presented me with all available service and support options, as well as all available providers of these services and supports. The providers of services and supports listed on this plan represent my choice. My support coordinator has also informed me of my rights according to Policy 1-1, Individual Rights, and my right to a hearing according to Policy 1-5, Notice and Hearings for Agency Actions. I understand that if I disagree with the above choice of providers that I have a right to a hearing within the time frames specified on form 490S, Your Hearing Rights.

Signatures

Person:_____ Date:_____

Support Coordinator:_____ Date:_____

Person's Legal Representative:_____ Date:_____